Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: INTEGRA SPECIALTY GROUP, P.A. 517 N. CARRIER PARKWAY, SUITE G GRAND PRAIRIE, TX 75050	MFDR Tracking #: M4-10-5306-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Carrier's Austin Representative Box #: OLD REPUBLIC GENERAL INSURANCE Box #: 42	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position statement in accordance with rule §133.307. The following is taken from the DWC-60 table of disputed services: "Not subject to Pre-Authorization, Pre-Authorized - #7839758/Per MAR, Per MAR Fee Guidelines"

Amount in Dispute: $15, 042.62

PART III: RESPONDENT'S POSITION SUMMARY

The respondent did not respond to this dispute.

Response Submitted by: N/A

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
9/2/09	90801	N/A	$229.39	$0.00
10/12/09	90801	N/A	$229.39	$0.00
10/26/09	97799-CP	8 x $100.00 = $800.00	$800.00	$800.00
10/28/09	97799-CP	8 x $100.00 = $800.00	$800.00	$800.00
10/29/09	97799-CP	8 x $100.00 = $800.00	$800.00	$800.00
10/30/09	97799-CP	8 x $100.00 = $800.00	$800.00	$800.00
11/3/09	97799-CP	8 x $100.00 = $800.00	$800.00	$800.00
11/4/09	97799-CP	8 x $100.00 = $800.00	$800.00	$800.00
11/5/09	97799-CP	8 x $100.00 = $800.00	$800.00	$800.00
11/6/09	97799-CP	8 x $100.00 = $800.00	$800.00	$800.00
11/9/09	97799-CP	8 x $100.00 = $800.00	$800.00	$800.00
11/10/09	97799-CP	8 x $100.00 = $800.00	$800.00	$800.00
11/12/09	97799-CP	8 x $100.00 = $800.00	$800.00	$800.00
11/13/09	97799-CP	8 x $100.00 = $800.00	$800.00	$800.00
11/16/09	97799-CP	8 x $100.00 = $800.00	$800.00	$800.00
11/17/09	97799-CP	8 x $100.00 = $800.00	$800.00	$800.00
11/18/09	97799-CP	8 x $100.00 = $800.00	$800.00	$800.00
11/19/09	97799-CP	8 x $100.00 = $800.00	$800.00	$800.00
11/20/09	97799-CP	8 x $100.00 = $800.00	$800.00	$800.00

11/23/09	97799-CP	8 x $100.00 = $800.00	$800.00	$800.00
12/22/09	99213	53.68 ÷ 36.0666 x $61.76 = $91.92	$91.92	$91.92
12/30/09	99213	53.68 ÷ 36.0666 x $61.76 = $91.92	$91.92	$91.92
			Total Due:	$14, 583.84

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of health care.
3. 28 Tex. Admin. Code §133.240 sets out the guidelines for medical payments and denials.
4. 28 Tex. Admin. Code §134.203 sets out the medical fee guidelines for professional services rendered on or after March 1, 2008.
5. 28 Tex. Admin. Code §134.204 sets out the medical guidelines for workers' compensation specific services.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Original explanation of benefits

   - 26 – based on peer review
   - W12 – extent of injury

   Reconsideration explanation of benefits

   - BL - (197) Precertification/authorization/notification absent.
   - 19 – (197) This line was included in the reconsideration of this previously reviewed bill

Issues

1. Did the requestor seek preauthorization for the services in dispute?
2. Are there unresolved extent of injury issues?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed the above CPT codes and dates of service and submitted original EOB's supporting that the insurance carrier denied all of the services with reason codes "26-based on peer review" and "W12-extent of injury" except for dates of service 9/2/09 and 10/12/09. Neither the requestor nor the respondent submitted position statements to this dispute. The disputed services will therefore be reviewed per applicable rules and fee guidelines. The requestor only submitted the first page of the original EOB's for these two dates of service and the second page with the denial reasons is missing. However, the requestor submitted reconsideration EOB's for these dates of service which include denial reason "BL- precertification/authorization/notification absent". The requestor billed CPT code 90801 (Psychiatric diagnostic interview examination) for both dates of service. Pursuant to rule §134.600(p)(7) Non-emergency health care requiring preauthorization includes: all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or Division exempted return-to-work rehabilitation program. The requestor did not submit documentation to support that these services were preauthorized and Division records support that the requestor is not in a Division exempted return to work rehabilitation program. Therefore, reimbursement to the requestor for these dates of service is not recommended.

2. The requestor disputes CPT code 97799-CP for chronic pain management services rendered for 18 visits from 10/26/09 thru 11/23/09. The requestor is also disputing CPT code 99213 for office visits for dates of service 12/22/09 and 12/30/09. The insurance carrier denied these services with reason codes "26-based on peer review" and "W-12 extent of injury". The requestor submitted a copy of a preauthorization, supporting approval of 160 hours of chronic pain management with start date 10/16/09 and end date 12/16/09. Pursuant to rule §133.240(b) For health care provided to injured employees not subject to a workers' compensation health care network established under Insurance Code Chapter 1305, the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized… Therefore, the insurance carrier's denial of "26-based on peer review" is not supported. The requestor also submitted a copy of a Contested Case Hearing (CCH) Decision and Order (DO) signed on 3/4/2010 which supports "The compensable injury of October 4, 2008 does extend to include acute and chronic lumbar pain with bilateral radiculopathy consistent with the described method of injury and lumbar disc disorder with neuroforaminal encroachment from L3-S1." The requestor's submitted documentation supports that the compensable

injury was treated. Therefore, the insurance carrier's denial of "W-12 extent of injury" is not supported and reimbursement to the requestor for 18 visits of chronic pain management and for 2 office visits rendered on 12/22/09 and 12/30/09, is recommended. Pursuant to rule §134.204(h)(1)(A) The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of…Chronic Pain Management. If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $14,583.84.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $14,583.84 plus applicable accrued interest per Division rule at 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	**6/29/11** Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.